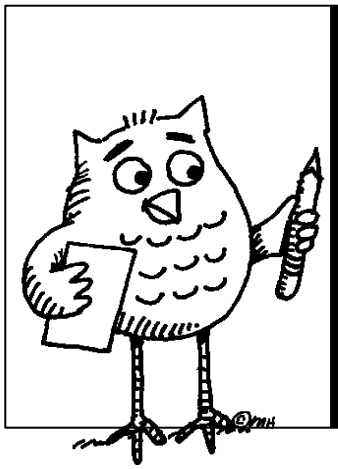

Waiver Wise

Technical Assistance for the Community Options Program Waiver COP-W

Wisconsin Department of Health & Family Services • Division of Disability and Elder Services
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Medicaid Bedhold Days for Therapeutic Visits versus Discharge from the Nursing Home

This technical assistance document highlights the differences in coverage for services when:

- Individuals leave the nursing home for a temporary visit in the community with family or friends and intend to return to the nursing home, or
- Individuals wish to leave the nursing home for a permanent community placement.

Temporary Visits to Community

From time to time, an individual in the nursing home may request to leave the nursing home to temporarily visit friends or relatives in the community with the intent of returning to the nursing home. These visits, called **therapeutic visits**, must be approved by the physician in the resident's plan of care and may last one or more days. During a therapeutic visit, the temporarily vacated nursing home bed will be "on hold" until the individual returns to the nursing home.

When the individual is a Medicaid recipient and while the nursing home bed is "on hold," Medicaid will continue to reimburse the nursing home 85 percent of the nursing home daily rate for the unoccupied bed, but only if - *during the previous month* - one of the following two conditions was true:

1) The nursing home occupancy threshold was 95 percent, or
2) There were eight vacant beds or less.

Under Medicaid, periods of time when Medicaid reimbursement to the nursing home for a vacant bed continues are called **bedhold days**. Note that, although the resident is still liable for his or her contribution to the cost of care to the facility during bedhold days, the nursing home cannot charge the resident for the difference between the 85 percent rate it receives from Medicaid and the usual and customary rate (see the Wisconsin Medicaid Provider Handbook, Part Y – Nursing Home Services, Section H).

What type of coverage exists for services needed in the community during a therapeutic visit?

1) **Medicaid non-covered services.**
   An individual who leaves the nursing home for a therapeutic visit may need a number of services, like home health care, personal care, assistance with activities of daily living, transportation, etc.

   No Medicaid coverage is available for services in the community that are included in Medicaid's continued reimbursement to the nursing home during a therapeutic bedhold period. Under Medicaid, such reimbursement is considered duplicative. For example, home health, personal care services and DME are already included in the nursing home's daily rate. Consequently, those services are not covered in the community unless the resident is formally discharged from the nursing home.

2) **Medicaid covered services.**
   During therapeutic bedhold days Medicaid does cover hospital, physician, chiropractic and certain other professional services, in addition to prescription medicine and transportation, because these services are not included in the nursing home daily rate.

Permanent Community Placement

An individual who is discharged from the nursing home for a community placement would be able to access all Medicaid card services when appropriate criteria are met. The discharge option may be suitable when the availability of beds in the particular nursing home or in the particular county is not an issue - for example, if there is not a waiting list at the individual's preferred nursing home or appropriate alternatives exist. The availability and affordability of alternate residential settings, such as CBRFs, or adult family homes, etc., should be explored, in case home care is not feasible.

What type of coverage exists for services in the community for individuals who are seeking community placement?

In counties where COP funding is available and there is no waiting list, an individual who intends to relocate in the community may receive coverage for COP covered services for up to 90 days, while planning for a permanent community placement. Please see DDES Memo Series 2003-11, dated October 20, 2003 regarding the topic of transitional services covered under Medicaid community waivers for persons leaving the nursing home for community living.

When services such as personal care, home health care or durable medical equipment will be needed upon discharge from the nursing home, prior authorization from Medicaid may be required. Providers should begin the process of requesting a prior authorization well before the individual is discharged from the nursing home.

A discharged individual may also access Medicare or private insurance coverage for home health visits if Medicare and private insurance criteria are met. Informal supports should also be explored until Medicaid or other coverage becomes available.

What is Medicaid "Bed Banking"?

Medicaid bed banking is a way for nursing homes to manage occupancy rates and it is being addressed here solely for an explanation of the term.

To meet the 95 percent occupancy level discussed under the Temporary Visits to Community section of this document, nursing homes sometime use "bed banking," which simply means that nursing homes are allowed to periodically "bank" (or reserve) an unlimited number of licensed beds. Although not de-licensed, banked beds are not available for occupancy by any residents. Annually, nursing homes lose 10 percent of the beds they bank. Nursing homes continue to be charged a daily assessment, sometimes called a "bed tax" for licensed beds that are banked.